Request for Appeal

Denied Medical Exemption Request

Date:_____

Parent Name:_____

Address: _____ E-mail Address: _____

City:_____ State:_____ Zip:_____ Phone:_____

Child's Name: _____Date of Birth: _____/_____/_____

Child's Age:_____ County of School: _____

Date of Local Health Officer Exemption Request Denial:_____

Below: Please explain what you feel the State Health Officer should consider as the basis for reversing the decision of the Local Health Officer. (Attach additional information as necessary)

Parent Signature: _____ Date:_____

(May be typed for E-mail)

May be sent by **Mail: West Virginia Department of Health and Human Resources**
Bureau for Public Health
Attention: State Health Officer
350 Capitol Street Room 702, Charleston, WV 25301

or **Fax: (304)-558-1035**

or **E-mail:** **Send To: vaccineexemption@wv.gov**